Emergency Medical Responder License Renewal Application

Idaho Emergency Medical Services Bureau

Send completed form to Idaho EMS Bureau, PO Box 83720, Boise, ID 83720-0036 or Fax to 208-334-4015

Completion checklist: ☐ License Holder Signature ☐ Affiliating Agency Authorized Signature
☐ Continuing Education Record completed and signed ☐ Skills Verification completed and signed

Name _____
Last Name First Name Middle Name/Initial

Idaho EMS License # _____ or Social Security # _____

Circle the highest level of education: GED High School Diploma College: 1 2 3 4 5 6 7 8 Gender ☐ F ☐ M

Home Phone # _____ Work Phone # _____ Cell Phone # _____

E-Mail Address _____

Mailing Address _____
Street City State Zip County

Affiliation:

Qualifying Agency of Affiliation _____ Agency License # _____

Agency Authorized Signature _____ _____
Signature Printed Name

Career status for qualifying agency: ***Volunteer*** ☐ True ☐ Compensated ***Career*** ☐ Full Time ☐ Part Time

List all agency or hospital affiliations or associations (Use additional form if necessary.)

Agency/Hospital _____ ***Volunteer*** ☐ True ☐ Compensated ***Career*** ☐ Full Time ☐ Part Time

Agency/Hospital _____ ***Volunteer*** ☐ True ☐ Compensated ***Career*** ☐ Full Time ☐ Part Time

Agency/Hospital _____ ***Volunteer*** ☐ True ☐ Compensated ***Career*** ☐ Full Time ☐ Part Time

I am also an Idaho licensed/certified health care provider as a(n) (circle all that apply): MD / DO / PA / RN / RT / other (please specify) _____

Have you been charged with or convicted of a felony that you have not previously disclosed to the EMS Bureau? ☐ Yes ☐ No
If yes please explain: _____

Has an EMS agency taken any adverse action against you that you have not previously disclosed to the EMS Bureau? ☐ Yes ☐ No
If yes, please explain: _____
(Separate sheets may be attached)

Signature:

I hereby affirm the information herein is true and correct, and that I meet all requirements for EMS licensure as established by the State of Idaho.

Signature of Candidate _____ Date signed _____

For Bureau Use Only

Received in Bureau

EMR License Renewal Education Record Candidate Name:_____

Each license cycle, an EMR must complete:

-A minimum of 24 hours of continuing education (CE)

-A minimum of two (2) venues (at least one (1) hour in each)

- **Transition Education was 75% (at least 18 hours) of this license cycle exempting me from the venue requirement Yes___ No___**

-A minimum of eight (8) categories

- Pediatric Assessment and Management must be a minimum of two (2) hours
- EMS Systems and Operations must be a minimum of three (3) hours, which includes both Landing Zone Officer (LZO) and Extrication Awareness courses

		Venues										**Total hours in each Category** (add across)
		Structured classroom sessions	Refresher programs that revisit original curriculum and have an evaluation component	Nationally recognized courses	Regional and national conferences	Teaching topical material	Agency Medical Director approved self-study or directed study	Case reviews and grand rounds	Formal distance learning	Journal article review with an evaluation instrument	Author or co-author an EMS related article in a nationally recognized publication	
Categories	Pediatric assessment and management *(2 hrs required)*											
	EMS systems and operations *(3 hours required for LZO and Extrication Awareness)*											
	o Must have a minimum of two (2) hours per category in at least six (6) of the remaining categories											
	Anatomy and physiology											
	Medical terminology											
	Pathophysiology											
	Life span development											
	Public health											
	Pharmacology											
	Airway management											
	Assessment											
	Medical conditions											
	Shock and resuscitation											
	Trauma											
	Special patient populations											
											TOTAL HOURS	

During this license cycle, I have completed and documented the following:

Extrication Awareness: ☐ EMS Bureau Learning Management System, or ☐ an EST Certificate **Yes___ No___ Date: _____**

Landing Zone Officer (LZO) training: ☐ Distributed learning, or ☐ Classroom **Yes___ No___ Date: _____**

I certify that the information I have provided within this document including any attached supplemental information is true, complete and correct. I further understand that failing to disclose information or falsification of information may be punishable by prosecution for perjury pursuant to Section 18-5401, Idaho Code. I understand that this submission may be audited and I may be expected to produce valid documentation supporting the information I have submitted. Violations of IDAPA 16.01.12.10, "Falsification of Applications or Reports" may result in an EMS license denial, refusal to renew, suspension, or revocation.

_____ _____

Candidate signature Date

EMR Skills Verification Candidate Name: _____

As the Physician Medical Director for the above named EMS Agency, I attest that this license renewal candidate has demonstrated proficiency in the skills and knowledge necessary to provide safe and effective patient care at the EMR license level and in the recognition and management of traumatic injuries and medical life threats or conditions for the pediatric, adult, geriatric and special needs populations. Furthermore, I attest to the competency of this candidate in all skills and interventions within the "floor" of the Idaho EMS Physician Commission Scope of Practice that includes:

- Airway, ventilation, and oxygenation
- Cardiovascular and circulation
- Immobilization
- Medication administration
- Normal childbirth
- Patient care reporting documentation and
- Safety and operations.

Is the scope of practice for this license renewal candidate restricted as a result of failure to meet or maintain proficiencies? Yes No

If yes, please provide details:

_____ _____ _____

Signature of MD Printed Name Date

If the Medical Director would like to appoint a designee for skills verification at the EMR and EMT level, please fill out the Medical Director Skills Verification Delegation of Signature Authority form. This document is located on the EMS Bureau website at www.idahoems.org under Provider Licensure forms.

If you have completed your Transition Course and desire to transition your license to the new curriculum level, please submit this form with your renewal application.

IDAHO DEPARTMENT OF HEALTH & WELFARE

EMS Personnel License Transition Application

Idaho Emergency Medical Services Bureau

IDAHO E·M·S

Send completed form to: Idaho EMS Bureau, PO Box 83720, Boise, ID 83720-0036 or
Fax to: 208-334-4015 or Email to: EMSProvLic@dhw.idaho.gov

Level Applying For: ☐ Emergency Medical Responder (EMR) 2011 ☐ Emergency Medical Technician (EMT) 2011

SSN –or- EMS License # _____

Name _____
Last Name First Name Middle Name

Transition Course # _____

Transition Education was completed within one (1) license duration (36 months) Yes___ No___ Date From: _____ To: _____

I hereby affirm the information herein is true and correct, and that I meet all requirements for an updated EMS license as established by the State of Idaho.

_____ _____

Signature of Applicant Date signed